MISSISSIPPI MSCHIP NCPDP ENCOUNTER CLAIMS

Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet

GENERAL INFORMATION

Payer Name: Mississippi Division of Medicaid	Date: October 1, 2018	
Plan Name/Group Name: MS Medicaid Fee For Service	BIN: 610084	PCN: DRMSPROD
Plan Name/Group Name: MS Medicaid Fee For Service (test)	BIN: 610084	PCN: DRMSTEST
Processor: Conduent		
Effective as of: 10/01/2018	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: October, 2007	NCPDP External Code List Version Date: March, 2010	
Contact/Information Source: Website: http://www.medicaid.ms.gov/Pharmacy.aspx Conduent Provider and Beneficiary Services: 8ØØ-884-3222		
Certification Testing Window: Certification is not required		
Certification Contact Information: N/A		
Provider Relations Help Desk Info: Conduent Provider and Beneficiary Services 8ØØ-884-3222		
Other versions supported: N/A		

OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B1	Billing
B3	Rebilling
B2	Reversal

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	610084	M	
1Ø2-A2	VERSION/RELEASE NUMBER	D.Ø	M	
1Ø3-A3	TRANSACTION CODE	B1 = Billing B2 = Reversals B3 = ReBill	M	Billing, Reversal, Rebill
1Ø4-A4	PROCESSOR CONTROL NUMBER	DRMSPROD = Production DRMSTEST = D.Ø test	M	
1Ø9-A9	TRANSACTION COUNT	1 = One Occurrence	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 – National Provider Identifier	M	NPI mandated Ø2/Ø1/2ØØ8
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	NPI mandated Ø2/Ø1/2ØØ8 (This is the billing pharmacy's NPI)
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	ØØØØØØØØØØ	M	Populate with zeros

Insurance Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	9 digit Medicaid ID number	M	
3Ø1-C1	GROUP ID	SIPPI	R	
3Ø3-C3	PERSON CODE	001 = Cardholder	R	

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH	CCYYMMDD	R	
310-CA	PATIENT FIRST NAME	Up to 12 characters	R	
311-CB	PATIENT LAST NAME	Up to 15 characters	R	
3Ø5-C5	PATIENT GENDER CODE	Ø=Not specified 1=Male 2=Female	R	
3Ø7-C7	PLACE OF SERVICE	All published CMS values will be accepted	RW	Required: '11' (Office) required when billing Clinician Administered Drug/Implantable Drug System Devices (CADD) as defined by MS Medicaid.
335-2C	PREGNANCY INDICATOR	Blank=Not Specified 1=Not pregnant 2=Pregnant	RW	Required if pregnant

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills		Partial Fills are not allowed.

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	National Drug Code (NDC)	M	
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	CCYYMMDD	M	For encounter claims only, the CCO must submit the date they originally received the claim from the pharmacy. This usage is outside the norm for NCPDP claims, but it was requested by DOM for MSCAN encounters and we will use it for MSCHIP encounters as well.
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Refill number	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		RW	*Reserved for future use*
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø=Default, no product selection 7=brand mandated by law	RW	Required when submitting a claim for Narrow Therapeutic Index Drugs

414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
415-DF	NUMBER OF REFILLS AUTHORIZED		R	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
42Ø-DK	SUBMISSION CLARIFICATION CODE	13=Payer Recognized Emergency	RW	Required during officially declared emergencies when it is necessary to override service limit edits
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not Specified 2=Other coverage exists - payment collected 3=Other coverage billed - claim not covered 4=Other coverage exists - payment not collected	RW	Required when other coverage exists
418-DI	LEVEL OF SERVICE	3=Emergency	RW	Required when submitting a claim for a 72-hour Emergency Supply

Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	This field is required to be submitted in D.0 which is a change from 5.1
412-DC	DISPENSING FEE SUBMITTED		RW	Required if necessary as component part of Gross Amount Due
426-DQ	USUAL AND CUSTOMARY CHARGE		R	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
43Ø-DU	GROSS AMOUNT DUE		R	This field is required to be submitted in D.0 which is a change from 5.1
423-DN	BASIS OF COST DETERMINATION		RW	*Not currently used but reserved for future use.*

Prescriber Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1=National Provider Identifier (NPI)	R	Prescriber NPI is required effective 05/23/2008.
411-DB	PRESCRIBER ID	National Provider Identifier (NPI)		NPI mandated 05/23/2008

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is REQUIRED.	X	Maximum of 5 times. Required for Encounter Claims whether TPL exists on the original pharmacy claim or not. If there is no TPL, on the original claim, then we would expect a count of 1 in field 337-4C. We expect to see the CCO's payment and/or reject information in segment AM05. If there is TPL on the claim, then we would expect to receive the count of TPL payers +1 (for the CCO's segment) in 337-4C.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	1-5	R	Required.
338-5C	OTHER PAYER COVERAGE TYPE	01 – 09	R	For the CCO's COB segment, we expect a value of 01 if the CCO is the primary payer. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
339-6C	OTHER PAYER ID QUALIFIER		R	Required. We expect a value of '1D' to denote that the CCO is submitting their Medicaid Number in field 34Ø-7C. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
34Ø-7C	OTHER PAYER ID	10 Characters	R	For the CCO's COB payer segment, we expect to see the CCO's Medicaid ID for their MSCHIP plan as assigned by DOM/Conduent. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
443-E8	OTHER PAYER DATE	CCYYMMDD	R	For the CCO's COB segment, this is the day they paid the claim. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
993-A7	INTERNAL CONTROL NUMBER	30 Characters	RW	Required on the CCO's COB segment. This is the CCO's internal claim number. For true TPL, this is a pass through from the original NCPDP pharmacy claim and may not be mandatory/required.
341-HB	OTHER PAYER AMOUNT PAID COUNT	1-9	R	On the CCO's COB segment, we expect a value of 3 as the CCO will report their paid amount, allowed/calculated amount, and copay amount. For true TPL, this is a pass through from the original NCPDP pharmacy claim.

342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø9 = Compound Preparation Cost 1Ø = Sales Tax 99 = OTHER (COB allowed/calculated amount)	R (Repeating)	All value qualifiers are accepted as payment from the other payer. CCOs will send one segment with '07 – Drug Benefit' to show their amount paid, another with '99 – OTHER' to show their allowed/calculated amount, and another with '04 – Administrative' to show their copay amount. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
431-DV	OTHER PAYER AMOUNT PAID	S$$$$$$cc	R	CCOs will send three occurrences for their COB segment, one for their paid amount, allowed/calculated amount, and copay amount, as described above for field 342-HC. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
471-5E	OTHER PAYER REJECT COUNT	1-5	RW	This field is required when CCOs are communicating their rejected claims per DOM's request. For true TPL, this is a pass through from the original NCPDP pharmacy claim.
472-6E	OTHER PAYER REJECT CODE		RW	Note: This field must only contain the NCPDP Reject Code (511-FB) values.

DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when DUR is returned on Rejection and pharmacy wishes to submit reason DUR rejection should be overridden.

	DUR/PPS Segment **Segment Identification (111-AM) = "Ø8"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
439-E4	REASON FOR SERVICE CODE	See attached list of valid values.	RW	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.
44Ø-E5	PROFESSIONAL SERVICE CODE	See attached list of valid values	RW	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.
441-E6	RESULT OF SERVICE CODE	See attached list of valid values	RW	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	*Not currently used, but reserved for future use*.

	Compound Segment **Segment Identification (111-AM) = "1Ø"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

Clinical Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when Diagnosis code is necessary for Claim adjudication

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	Diagnosis Code Count	Maximum Count of 5	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	Diagnosis Code Qualifier	01=ICD9	RW	Required if Diagnosis Code (424-DO) is used
424-DO	Diagnosis Code		RW	The value for this field is obtained from the prescriber or authorized representative. Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs.

CLAIM REVERSAL TRANSACTION (B2)

Claim reversals (B2 Transactions) use the same Transaction Header Segment, Insurance Segment, and Claim Segment as Claim billing (B1) and Claim rebilling (B3) above. Other segments are not supported **for claim reversals.**

DUR CODES

Reason for Service Code Values – Field 439-E4

ADMINISTRATIVE	DOSING/LIMITS	DRUG CONFLICT	DISEASE MANAGEMENT	PRECAUTIONARY
AN – Prescription Authentication	ER – Overuse	AT – Additive Toxicity	AD – Additional Drug Needed	DF – Drug-Food Interaction
CH – Call Help Desk	EX – Excessive Quantity	DA – Drug-Allergy	AR – Adverse Drug Reaction	DL – Drug-Lab Conflict
MS – Missing Information/Clarification	MX – Excessive Duration	DC – Drug-Disease (inferred)	CS – Patient Complaint/Symptom	DS – Tobacco Use
NA – Drug not available	HD – High Dose	DD – Drug-drug interaction	DM – Apparent Drug Misuse	OH – Alcohol conflict
NC – Non-covered drug purchase	LD – Low Dose	DI – Drug Incompatibility	ED – Patient Education/Instruction	SE – Side effect
NF – Non-formulary drug	LR – Underuse	IC – Iatrogenic condition	ND – New disease/diagnosis	
NP – New patient processing	MN – Insufficient Duration	ID – Ingredient duplication	NN – Unnecessary drug	
PS – Product selection opportunity	NS – Insufficient Quantity	MC – Drug-disease (reported)	PC – Patient Question/concern	
PP – Plan Protocol	SF – Suboptimal dosage form	NR – Lactation/nursing interaction	PN – Prescriber consultation	
TP – Payer/processor question	SR – suboptimal regimen	PA – Drug-age	RF – Health Provider referral	
		PG – Drug –pregnancy	SD – Suboptimal Drug/indication	
		PR – Prior adverse reaction	TN – Laboratory test needed	
		SX – Drug-gender		
		TD – Therapeutic duplication		

Profession Service Code Values – Field 440-E5

ADMINISTRATIVE	PATIENT CARE
ØØ – No intervention	AS – Patient Assessment
FE – Formulary enforcement	CC – Coordination of care
GP – Generic product selection	DE – Dosing evaluation/determination
PH – Patient medication history	MØ – Prescriber consulted
SW – Literature search/review	MA – Medication administration
TC – Payer/processor consulted	MR – Medication review
TH – Therapeutic product interchange	PØ – Patient consulted
	PE – Patient Education/instruction
	PF – Patient referral
	PM – Patient monitoring
	RØ – Pharmacist consulted other source

	RT – Recommended laboratory test
	SC – Self-care consultation

Result of Service Codes – Field 441-E6

DISPENSED	NOT DISPENSED	PATIENT CARE
ØØ – Not specified	2A – Prescription not filled	3A – Recommendation accepted
1A – Filled as is, false positive	2B – Not filled, directions clarified	3B – Recommendation not accepted
1B – Filled Prescription as is		3C – Discontinued drug
1C – Filled, with different dose		3D – Regimen changed
1D – Filled, with different directions		3E – Therapy changed
1E – Filled, with different drug		3F – Therapy changed – cost increase acknowledged
1F – Filled, with different quantity		3G – Drug therapy unchanged
1G – Filled, with prescriber approval		3H – Follow-up report
1H – Brand-to-generic change		3J – Patient referral
1J – Rx to OTC change		3M – Compliance aid provided
1K – Filled with different dosage form		